STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Services

In the matter of

XXXXX
Petitioner **File No. 87326-001**
v

Physicians Health Plan of Mid-Michigan
Respondent
_____/

Issued and entered
This 28th day of February 2008
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On January 23, 2008, XXXXX, authorized representative of his wife XXXXX (Petitioner), filed a request for external review with the Commissioner of Financial and Insurance Services under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*. On January 30, 2008, after a preliminary review of the material submitted, the Commissioner accepted the request.

The issue in this external review can be decided by a contractual analysis. The contract here is the certificate of coverage issued by Physicians Health Plan of Mid-Michigan (PHPMM), a health maintenance organization. The Commissioner reviews contractual issues under MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II
FACTUAL BACKGROUND

The Petitioner receives health benefits from PHPMM under a high deductible health plan. The plan has an annual family deductible of $4,000.00 for in-network services and $8,000.00 for non-network services. The Petitioner's benefits are defined in the certificate of coverage (the certificate).

From January 8 through March 9, 2007, the Petitioner received physical therapy (PT) from XXXXX, a non-network provider. PHPMM covered the services but applied all of the allowed charges to the Petitioner's 2007 non-network deductible. The Petitioner appealed, asking PHPMM to pay the claims at the network level.

PHPMM maintained its determination on the claims. The Petitioner exhausted PHPMM's internal grievance process and received its final adverse determination letter dated December 14, 2007.

III
ISSUE

Did PHPMM properly apply the deductible for the Petitioner's PT claims?

IV
ANALYSIS

Petitioner's Argument

The Petitioner disagrees with PHPMM's decision to apply charges for the PT to her non-network deductible, leaving her responsible for paying the charges. She argues that PHPMM should provide in-network coverage for the services because of the claims processing problems she experienced during the 2007 contract year (e.g., contract numbers were changed, the mailing address for claims was incorrect, PHPMM mistakenly denied claims saying her coverage had expired).

The Petitioner says if PHPMM had been timely in giving the correct reason for not paying the PT claims she could have obtained care from a network provider. Instead, she says

she was not made aware that the allowed charges would be applied to the new high non-network deductible until after she had completed her treatment.

The Petitioner believes PHPMM should take some responsibility for its failure to properly and timely process it's claims and should pay her claims as an in-network benefit and not apply them to her deductible.

PHPMM's Argument

In its final adverse determination, PHPMM said that it denied Petitioner's request to provide coverage at the in-network level because XXXXX "does not participate with PHPMM or PPOM and physical therapy services are available within the PHPMM and PPOM networks."

PHPMM's certificate of coverage describes the annual deductible as "The amount you pay for Covered Health Services before you are eligible to receive benefits." The Petitioner's annual family deductibles are described this way in the certificate in *Section 1: What's Covered – Benefits*:

Amounts
Network
For single coverage, the Annual Deductible is $2000 per calendar year.
If more than one person in a family is covered under the Policy, the single coverage Annual Deductible stated above does not apply. For family coverage, the family Annual Deductible is $4000 per calendar year. No one in the family is eligible to receive Benefits until the family Annual Deductible is satisfied.
Non-Network
For single coverage, the Annual Deductible is $4000 per calendar year.
If more than one person in a family is covered under the Policy, the single coverage Annual Deductible stated above does not apply. For family coverage, the family Annual Deductible is $8000 per calendar year. No one in the family is eligible to receive Benefits until the family Annual Deductible is satisfied.

When services are received from a non-network provider, the $8,000.000 annual non-network deductible must be satisfied before PHPMM makes any payment. Since XXXXX is a non-network provider, PHPMM says it applied the allowed charges for the PT to the Petitioner's non-network deductible, a decision it believes is consistent with the certificate.

PHPMM further says that the Petitioner's authorized representative acknowledged in a telephone call with its customer service representative in September 2007 that he did not look up the network status of XXXXX before the Petitioner proceeded with received services.

Commissioner's Review

The Petitioner's coverage allows her to choose to receive medically necessary services from either network or non-network providers. However, services from non-network providers come with significantly higher out-of-pocket costs.

The certificate explains that while prior notification is not required, short-term outpatient rehabilitation services from a non-network provider are subject to the annual deductible (page 31):

Description of Covered Health Service	**Is Notification Required?**	**Your Copayment Amount** % Copayments are based on a percent of Eligible Expenses	**Does Copayment Help Meet Out-of-Pocket Maximum?**	**Do you Need to Meet Annual Deductible?**
28. Rehabilitation Services-Outpatient Therapy Short-term outpatient rehabilitation services for: • Physical therapy	***Network*** No ***Non-Network*** No	0% 30%	No Copayment Yes	Yes Yes

It is undisputed that XXXXX is a non-network provider. The certificate is clear that an $8,000.00 deductible applies if a member seeks covered services from a non-network provider (unless the services were not available from a network provider, which is not shown to be the case here). From the explanation of benefit forms in the record it appears that XXXXX charged $4,641.00 and PHPMM applied $4,142.00 (its allowed amount for the services) to the Petitioner's $8,000.00 deductible.

It may be true, as the Petitioner alleges that PHPMM made mistakes in processing her claims for PT benefits and was perhaps maladroit in its administration of her health care coverage. However, that fact, even if true, cannot be the basis of a decision here. In reviewing

a case under the Patient's Right to Independent Review Act, the Commissioner is bound by the terms and conditions of the certificate unless they are contrary to state law. The Petitioner received PT services from a non-network provider and the certificate plainly says that those services are subject to the non-network deductible.

After careful review of the arguments and documents presented by the parties, the Commissioner finds that PHPMM correctly applied the allowed charges for the Petitioner's PT services to her annual non-network deductible according to the terms and conditions of the certificate.

V
ORDER

The Commissioner upholds PHPMM's December 14, 2007, final adverse determination in the Petitioner's case. PHPMM properly applied the deductible for the PT services in question in this matter under the terms of its certificate of coverage.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the circuit court for the county where the covered person resides or in the Circuit Court of Ingham County.

A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Services, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.